LOUISIANA PATIENT'S COMPENSATION FUND
INSTITUTIONAL HEALTH CARE PROVIDERS' APPLICATION
(for those with underlying self-insurance)

NAME & PHYSICAL ADDRESS OF INSTITUTION **LICENSE #:** _____

License Number - Required

_____

Name of Institution - Required

_____

Institution's Physical/Street Address - Required

_____

Institution's Address Line 2

_____

City, State & Zip Code - Required

DATES OF ENROLLMENT APPLYING FOR: _____ **TO:** _____

Enrollment Dates - Required

AMOUNT OF SURCHARGE BEING REMITTED: _____

1. IS THERE A SEPERATE OWNER? ____ **No** **Yes** ____

IF SO, PLEASE PROVIDE THE NAME AND ADDRESS IF DIFFERENT FROM ABOVE HEALTHCARE PROVIDER?

2. OPERATIONS OF APPLICANT (Check ALL That Apply):

	Hospital - General			**Teaching Hospital**
	Hospital - Children			**Ambulance/EMS**
	Hospital - Psych			**Individual**
	Hospital - Rehab			**Partnership**
	Clinic Onsite/Type:			**Corporation**
	Clinic Offsite/Type:			**Government Entity**

Must advise the PCF of any offsite entities or multiple locations for which coverage is provided along with the address for each location and proof of underlying coverage.

3. PROFESSIONAL LIABILITY EXPOSURES (furnish daily census data):

Number of beds maintained: (Beds mean total number of beds, cribs and bassinets used for patients)		**Average Number Occupied:** (Average number occupied is the sum of the daily number of beds, cribs and bassinets used for patients during the preceding 12 months, divided by 365.)
	Acute	
	Skilled/LATC	
	Rehab	
	Psych	
ER Staffed By	9	

a. Number of outpatient visits: _____
(Including outpatient and ambulatory surgeries.)

b. Number of inpatient surgeries: _____

c. Number of outpatient, ambulatory and "day"surgeries*: _____
(*Included in "a" above.)

4. PROFESSIONAL EMPLOYEES:

a. Indicate total number of employees in class:

	Register Nurses		**LPN/LVNs**
	Pharmacists-(see rate manual)		**Heart-Lung Technicians**
	X-Ray Technicians		**Paramedics-(see rate manual)**
	Lab Technicians		**EMTs-(see rate manual)**
	Other		**Student Nurses**

b. Are above employees to be included as additional insureds? ☐ **No** **Yes** ☐

c. Employed physicians (including Medical Directors), surgeons, CRNAs, Surgical/Physician assistants, Nurse Practitioners and Pharmacists if paying for them separately must submit an individual application along with the appropriate surcharge.

5. PREVIOUS EXPERIENCE (NEW ENROLLEES ONLY):

a. Name of previous liability carrier: _____

b. List all claims or suits filed in the last ten years. Attach a separate list if necessary.

Date	Description	Open/Closed		Total Incurred

Your attention is directed to LAC 37:III, Chapter 11, §§1101-1105, which sets froth the cost and reserve reporting requirements which you must satisfy within the time allotted therein. Please note §1105 which provides for the cancellation of and termination of enrollment with the Patients' Compensation Fund for failure to comply with these reporting requirements.

I further certify that the appropriate security (proof of financial responsibility) is in place and current at the following institution:

_____ in the name of _____

INCLUSIONS: Employed Allied Healthcare Providers.
EXCLUSIONS: This does not include those who require a PCF surcharge, such as, NP's, PA's, CNS', CRNA's, etc.
PCF RESERVES THE RIGHT TO DENY COVERAGE FOR THE FOLLOWING:

(1) Injury arising out of a criminal act, including but not limited to sexual abuse or molestation, fraud committed by the insured or any person for whom the insured is legally responsible, and battery.

(2) Third (3rd) party claims filed by an injured party that was not a patient of the health care provider.

(3) Services or treatment rendered as a licensed provider in states other than Louisiana, even if the underlying insurer provides coverage for same.

07/28/2015

DATE **SIGNATURE OF ADMINISTRATOR**

CONTACT PERSON AND PHONE #: _____

EMAIL ADDRESS: _____

LOUISIANA PATIENT'S COMPENSATION FUND
P. O. BOX 3718
BATON ROUGE, LA 70821
FAX: (225) 342-5593

Any questions regarding this form may be emailed to: pcf-surcharge@la.gov
A PRINTED, SIGNED COPY OF THIS FORM MUST BE MAILED/FAXED TO PCF.

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